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Piedmont HealthCare
Mooresville Dermatology

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ Print Patient Name	_____ Date of Birth
_____ Street Address / P.O. Box	_____ Phone (home)
_____ City / State / Zip Code	_____ Phone (work)

1) I hereby authorize the **Medical Record personnel and/or the Privacy Officer of Piedmont HealthCare to facilitate the use or disclosure of the information as set forth below:**

SEND MEDICAL RECORDS TO:	**MEDICAL RECORDS FROM:**
_____ Name (facility/physician/person)	_____ Name (facility/physician/person)
_____ Complete Address	_____ Complete Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone Number & Fax Number	_____ Phone Number & Fax Number

The specific description of information that may be used/disclosed:

☐ Immunization Records ☐ Office Visit Notes ☐ X-Ray Reports ☐ Entire Record ☐ Lab Reports / Pathology Reports
☐ Other _____

Covering the dates of treatment from _____ ***(date)*** **to** _____ ***(date)*.**

I understand that the information released may include information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, or treatment for alcohol and/or drug abuse, unless otherwise specified here: ☐ **Do not release**

The information will be used/disclosed for the following purpose(s):

☐ Patient Request ☐ Transferring Physicians/Moving ☐ Attorney ☐ Insurance ☐ Referral from PHC Physician
☐ Other _____

2) **I understand that: i) the information disclosed to a third party in accordance with the terms of this authorization may be re-disclosed and; ii) once disclosed to a third party, my health information may no longer be protected by federal privacy regulations.**

3) **I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Piedmont HealthCare, except that:**

   a. **If I refuse to sign this authorization, and this authorization is for research purposes, the Piedmont HealthCare may refuse to allow me to participate in the research; and**

   b. **If the purpose of this authorization is to share pre-employment/employment screening tests with my prospective/current employer, Piedmont HealthCare may refuse to provide such testing.**

4. **I have been provided with a copy of Piedmont HealthCare's Notice of Privacy Practices. I understand that I may revoke this authorization at any time in writing to the PHC Privacy Officer (see Notice of Privacy Practices) or to the office where this authorization was submitted, except to the extent that information has already been released.**

5) **This authorization expires on _____ (insert date). If I fail to specify an expiration date, this authorization will expire automatically ninety (90) days from the date of signature.**

I have read and understand the information in this authorization. I certify that I have received a copy of this authorization.

_____ _____

Signature of Patient/Personal Representative **Date**

If personal representative, please check legal authority to act on patient's behalf and include legal documentation to confirm such authority.

□ Parent of Minor □ Guardian □Power of Attorney □Executor of Estate □ Other: _____

****** Please allow 5-10 working days for medical records to be processed******

NOTE: THERE MAY BE A CHARGE FOR COPYING YOUR RECORDS – APPLIED IN ACCORDANCE WITH NORTH CAROLINA LAW.

THE CHARGE FOR THIS SERVICE IS AS FOLLOWS, ACCORDING TO NORTH CAROLINA LAW:

$.75*/ pgs 1-25 $.50*/ pgs 26-100 $.25*/ pgs 101 and over

*Plus shipping and handling charges